South East London Integrated Care System

Leadership and Governance Proposals

August 2021

1. Purpose

1.1. To outline the proposed arrangements for the Integrated Care System's (ICS) key leadership and governance fora in South east London (SEL): the ICS Partnership (ICP) and the ICS NHS Board (ICB), such that they can operate on behalf of our population and system in shadow form before the end of quarter three 2021/22 and ahead of the assumed legal establishment of the ICS NHS Body on 1 April 2022.

> *Subject to legislation being agreed each ICS will comprise an:*
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> ***Integrated Care Partnership (ICP):*** *the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.*
>
> ***Integrated Care Board (ICB):*** *bringing the NHS together locally to improve population health and care.*

2. Context for proposals

> *The core purpose of an ICS is to:*
>
> ***1*** *Improve outcomes in population health and healthcare*
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> ***2*** *Tackle inequalities in outcomes, experience and access*
>
> ***3*** *Enhance productivity and value for money*
>
> ***4*** *Help the NHS support broader social and economic development*
>
> ***p20, Integrated Care Systems: Design Framework***

2.1. National guidance on ICS implementation continues to emerge, and the passage of the relevant Bill through Parliament is incomplete; however the direction of travel and likely national requirements are sufficiently clear, and enough ICS partnership engagement upon these matters has occurred to allow the proposals set out below to be taken forward in SEL.

2.2. The national ICS Design Framework makes clear the responsibilities of these elements of the system infrastructure - those areas that are prescribed and those that are left for local determination.

2.3. It is our clear conviction that:

- Whilst these governance elements of the ICS are critically important, the culture and ways of working for the ICS require greatest attention at this time and the arrangements outlined below will enable and not detract from that work
- That these proposals align to national expectations as they relate to SEL and reflect, as far as possible, the views and issues discussed with ICS partners both

before Christmas 2020 and in the last month following the publication of the ICS Design Framework in June 2021[1]. The process of local (ICS) partner discussions upon these matters has made clear a range of differing views upon these areas and it is clear (and we believe recognised by partners) that it will not be possible to generate proposals that satisfy all of those suggestions, issues and concerns.

- There will inevitably be future changes required to these arrangements as further information becomes available but they will not be material or prohibited by action as outlined here, and that the establishment of shadow arrangements that can oversee the implementation of the ICS as much as its delivery thereafter will be advantageous.
- These arrangements do not take account of, or pre-suppose the national offer and local (ICS) response for delegation of NHS England directly commissioned services with the exception of General Medical Services (General Practice) that represents a clear future stipulation of immediate delegation to the ICS[2]
- There will be opportunity for change to these proposals ahead of the final establishment of the ICS on 1 April 2022 should they be required by national direction or changes to the Bill as it comes in to law, the portfolio of directly commissioned services accepted by the ICS, or the financial framework established for the ICS (either externally or through the work the ICS is undertaking upon this area)

2.4. These proposals should be read in conjunction with the national ICS Design Framework, the content of which is not replicated here unless absolutely necessary for ease of reference.

3. Shadow arrangements

3.1. Notwithstanding the parliamentary process for ICS establishment and the iterative nature of national guidance, NHS England is clear in its expectation that the leadership of ICSs in England (the Chair and Chief Executive Officer) should have been appointed (Designate) by the end of quarter two 2021/22 and that core elements of the ICS governance should be agreed and in operation by the end of quarter three this financial year.

3.2. The SEL ICS Chair (Designate) appointment was confirmed in late July 2021. The appointment of the ICS Chief Executive occurs under a separate process to be outlined. The ICS Design Framework provides the 'blueprint' for the establishment of the structures outlined herein[3].

3.3. We believe these shadow arrangements will be critical:

- To facilitate the 'safe landing' of new arrangements with legal responsibilities on 1 April 2022

[1] The ICS Chair and Lead have undertaken two rounds of meetings with groups and individuals spanning all partners, including elected leaders and cabinet members of all six local authorities, all NHS Partners (including Chairs) and the wider system.

[2] Letter from Amanda Pritchard, Chief Operating Officer, 22 July 2021 confirming the intention to delegate some NHS England commissioning functions to integrated care systems from April 2022

[3] Further guidance upon the ICS constitution, an ICB Functions and Governance guide and details of the CCG Statutory functions to be conferred to NHS ICS Bodies are expected in August 2021

- To enable the effective organisation of current (non-statutory) ICS working and coordination, both an increasingly clear system requirement and regulatory expectation
- For the effective oversight of the development and implementation of the ICS in design terms, including responding to future guidance that will emerge
- To the development of an effective ICS that drives an organisational development (OD) activity alongside the establishment of a new statutory body.

3.4. The arrangements outlined below assume:

- The continuation of the current ICS Executive arrangements for SEL, albeit the Executive's composition and terms of reference may change over time
- A future decision upon delegation and its timing (April 2022 or April 2023) for current NHS England directly commissioned services
- A parallel commitment to the development of Place and Provider Collaborative leadership and governance arrangements as outlined below (section 5.16 - 5.23)
- The continuation of key ICS groups including: The Local Government Leaders and the Mayor group, the Local Government CEOs group, the Primary Care Leadership Group, current transformation and programme boards and Enabler Boards (e.g. The ICS People Board)

3.5. The future development of a small number of ICS committees or sub-groups of the ICB and ICP respectively ahead of legal establishment

3.6. All final arrangements for 1 April 2022 will be captured in an ICS Constitution to be agreed with NHS England. All prior arrangements represent non-statutory agreements across ICS partners.

4. ICS Governance requirements

4.1. The national design framework outlines a requirement for an Integrated Care Partnership (ICP) and a statutory NHS ICS Body (with its own unitary Board), now referred to as the ICB.

4.2. The ICP will be a committee rather than a body and will represent an equal partnership between the NHS and local authorities in any given ICS area. Beyond the agreement of its composition and Chair arrangements between the NHS and local government, its precise arrangements are permissive in national guidance, although it is required to develop and agree an 'Integrated Care Strategy' for its population.

4.3. The ICB is more prescribed by the national Design Framework in its roles and responsibilities (see **Appendix A**). It is required to have a unitary board with greater prescription over membership and committees.

4.4. In SEL we have a longstanding commitment to working in meaningful partnership with local authorities to ensure a truly integrated approach to improving the health outcomes and wellbeing of our residents and reducing inequalities. Whilst our ICS supports the ICP principles put forward by NHS England (see **Appendix B**), the national arrangements for the ICP alone are insufficient to secure that (SEL) commitment and so the ICS proposes further work to agree a number of powers for

the ICP that will provide meaningful influence of the committee over the shape of health and care services going forward.

4.5. In SEL we will establish arrangements that reflect the national guidance for the ICB. We have made a clear commitment to subsidiarity and the delegation of decision making, budgetary responsibility and delivery to partnerships focused upon Places - our six boroughs; and to those partnerships focused upon areas of care delivery - our Provider collaboratives (Acute and Mental Health). Our overall ICS governance arrangements will rely upon and therefore make some limited prescription upon the governance and leadership of those partnerships in order to enact safe delegation, alongside establishing clear delivery mandates and delegation agreements.

4.6. At all times our arrangements will be mindful of the statutory duties of our partner organisations and their Boards / governing bodies.

5. ICS Proposals

ICP: a committee

> *The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.*
>
> ***p20, Integrated Care Systems: Design Framework***

5.1. Beyond its requirement to develop and agree an Integrated Care strategy for its population, our arrangements will have an expectation of a true partnership of the NHS and Local Authorities in SEL and so it follows that the ICP will seek a way of working that sets expectations upon all partners to adhere to and act in accordance with that strategy and hold each other to account for doing so.

5.2. In addition the ICS will work over the coming period to agree a set of principles or conditions that the ICP can utilise to confirm that partner strategies and plans, delivery actions and budgets are aligned to the above principle. The ICP can expect to endorse financial allocative decisions on an annual basis and significant service changes as and when they occur in terms of those conditions being met. It is acknowledged that the scope of the committee will be wider than the narrow set of considerations that are the focus on this document. It is likewise recognised that the ICP will not undertake the role afforded Overview and Scrutiny arrangements of local government (whether undertaken at borough or SEL level).

5.3. In support of effective governance and working of the ICP, a limited membership is proposed (aligned to national guidance) with the ability to convene a much wider engagement forum that would include wider representation for example leaders from education, housing, leisure and commerce.

5.4. As a meaningful partnership of local government and the NHS a joint chairing arrangement is proposed between the NHS ICS Chair and one of the Leaders of the six Local Authorities in SEL.

5.5. The membership of the committee is proposed as below:

- ICS Chair
- ICS Chief Executive
- Elected Leaders (or their nominated cabinet members) of the following local authorities – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark
- Chairs of Bromley Healthcare (CIC), Guy's and St Thomas' Hospital NHS FT, Lewisham and Greenwich NHS Trust, King's College Hospital NHS FT, Oxleas NHS FT and South London and the Maudsley NHS FT
- A lead Director of Adult Social Care (drawn from the six postholders in SEL)
- A lead Director of Children's Services (drawn from the six postholders in SEL)
- A lead Director of Public Health (drawn from the six postholders in SEL)
- A senior representative of Kings Health Partners
- A Primary Care / Primary Care Networks representative
- A representative of the VCSE services in SEL
- A representative of the SEL Healthwatch organisations (coordinated arrangement)

5.6. The ICP would be expected to take any decision by consensus. The ICP would be supported by sub groups and officers of its various partner members. The ICP will meet in public and with opportunity for private meetings. The committee would reserve the ability to co-opt associates over time as future arrangements for Supra - ICS working emerge - e.g. London Ambulance Service (LAS) or Dartford and Gravesham NHS FT (DGT).

5.7. The national Design Framework makes clear that formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. Our proposed SEL arrangements are proposed in this context and will take due account of this work at the appropriate time.

ICB's Board

> ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population.
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> They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.
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> ***p12, Integrated Care Systems: Design Framework***

5.8. The NHS ICS Body in SEL will undertake the statutory and related functions afforded it by legislation (see **Appendix A**) and its choices upon delegated responsibilities from NHS England. Its constitution will reflect these requirements and those powers the NHS and local government agree for the ICP.

5.9. Our proposals for the composition of the ICB's Board adhere to the minimum requirements outlined in the design framework. Thereafter they are reflective of the SEL system and our commitments to particular ways of working - principally those of securing good governance and securing subsidiarity.

5.10. It is important to note that Partner members of the ICB Board outlined below are expected to bring the perspective and insight or their areas rather than acting as delegates or representatives of others or their own organisation. Our boroughs (Places) are recognised to have distinctive populations within SEL and as such their perspective is not homogenous, with the membership of the Board reflects that.

> *We expect all… partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.*
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> ***p20, Integrated Care Systems: Design Framework***

5.11. The Board of the ICB will be supported by an Executive Team drawn from the ICS and its partner bodies.

5.12. The membership of the ICB's Board is proposed as follows:

- ICS Chair
- Two ICS Non-Executive Directors
- ICS Chief Executive Officer
- ICS Chief Financial Officer
- ICS Medical Director
- ICS Director of Nursing
- Acute services Partner member
- Mental health services Partner member
- Community services Partner member
- Local Authority Partner member (One CEO)
- Primary Medical Services Partner member (Primary Care leadership Group Chair)
- Six Place Partner members (one per borough holding Executive responsibility for delegation to that Place)

> *All members of the ICS NHS board… will have shared corporate accountability for delivery of the functions and duties of the ICS and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.*
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> ***p19, Integrated Care Systems: Design Framework***

5.13. The Board will expect to receive the support of officers and specifically public health professionals.

5.14. It will, alongside the ICP, need to consider and agree the most effective mechanisms by which to secure public and patient engagement and demonstrate that its actions take due account of this engagement and public and patient feedback. It will meet in Public at least four times a year.

> *Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.*
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> ***p10, Integrated Care Systems: Design Framework***

5.15. In SEL Partner members drawn from acute, mental health, community and local government should be an individual (not a shared or short-term rotated role) determined by the relevant organisations in SEL in each case and then agreed with the ICS Chair.

5.16. The Partner member for Primary Medical Services should be the Chair of the Primary Care Leadership Group, agreed by the members of that group.

Places and Collaboratives

5.17. Whilst the 1 April 2022 agreement of delegated responsibilities and budgets within the ICS (to Places and Collaboratives) is being determined it is clear they will be made, in significant quantity and scope, to each of the six Places (nationally referred to as 'Placed Based Partnerships' and in SEL as Local Care Partnerships or LCPs) and to two 'formal' Provider Collaboratives – one for Acute care providers and one for Mental Health providers.

5.18. The ICS intends to operate with a high level of permissiveness in determining governance that 'works' for the purpose it is designed e.g. form following function. The operation of the ICS's intended operating model, including the board composition above will require some degree of consistency and stipulation in approach, however.

In the case of Provider Collaboratives:

5.19. The determination of the Acute, Mental Health and Community Partner members of the Board will be a matter for those collaborating partners provided the member is at Chief Executive level, holds a leadership position within those collaboratives and is agreed with the ICS Chair.

5.20. The governance arrangements for the 'formal' Provider Collaboratives are assumed to operate with a form of committee arrangement (across the partners Boards) that will allow for joint decision making in line with the mandate afforded the collaborative by the ICS. This should be outlined by those relevant collaboratives (Acute and Mental Health) and agreed with the ICB's Board (in designate form).

5.21. These proposals do not assume any specific delegation to a Community services collaborative, which will operate as a network for the sharing of best practice, informal collaboration and establishing core standards for delivery in SEL.

5.22. Any collaboration of providers beyond those outlined here are matters for those organisations working with the expressed agreement of the Place and formal collaboratives of which they are members.

In the case of Places:

5.23. Each place will be required to establish the following:

- A Local Care Partnership (LCP) Board (a committee of the ICB) with a Terms of Reference and set of agree responsibilities aligned to the delegation and mandate afforded to that place.
- It should have a membership that includes, as a minimum, agreed representation from local Primary Care Networks, Acute, Mental Health and Community services providers, the local authority (and specifically Adults and Children's services and Public Health), Healthwatch and the VCSE sector in that borough. The inclusion of the borough Director of Public Health is considered a requirement for each LCP.
- The LCP Board should agree a Chair of that Board agreed by the borough partnership, to be responsible for the effective running of that Board.
- Each LCP should have an appointed Executive leader, established through a recruitment process (to be agreed by the Partnership with the ICS Chair), that secures an executive with the capacity and capabilities required to hold and execute the mandate afforded that Place working with the LCP Board and local partners. That Leader – The 'Place Lead' will be the member of the ICB's Board.

> *Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.*
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> ***p25, Integrated Care Systems: Design Framework***

5.24. The local reporting of that LCP Board and the groups and local committees it interacts with are for local determination given the different arrangements within each borough provided the prime relationship, in governance terms, for NHS funds and responsibilities is with the ICB. The ICB remains accountable for those responsibilities and activities it delegates at all times.

5.25. The form of committee (NHS only, committee in common or joint committee) would need to be agreed according to its scope with the ICB and national guidance provides options for this.

6. Other arrangements

6.1. The final committees and sub-groups of the ICP and ICB's Board will be determined over the coming weeks.

6.2. As a minimum the ICB's Board will establish an Audit committee and a Remuneration committee (as required nationally). It will also require an Integrated Governance and Performance Committee (that will include, as a minimum, a Quality System Group) and governance arrangements that allow for the fulfilment of statutory responsibilities such as those relating to Adult and Children's safeguarding. This will be in addition to committees for each Place/ Borough (LCP Boards).

6.3. It is also a clear expectation in SEL that the ICS will be supported by:

- A Clinical and Professional Leadership Group
- A Patient and Public Engagement Group
- An Estates Board
- A Digital Board
- A People Board
- Core programme boards for key care pathways
- A Population Health and Inequalities Executive

7. Recommendations

7.1. The ICS Executive is asked to consider and endorse the arrangements outlined in this paper in order that they can form the basis for detailed implementation planning across the remainder of quarter two 2021/22 for moving to these Shadow arrangements in November/ December 2021.

7.2. Section 2.3 of this paper notes the opportunity for change to these proposals ahead of the final establishment of the ICS on 1 April 2022 should they be required by national direction or changes to the Bill as it comes in to law, the portfolio of directly commissioned services accepted by the ICS, or the financial framework established for the ICS (either externally or through the work the ICS is undertaking upon this area).

7.3. Following endorsement the ICS Executive can expect to receive specific plans for the enactment of these arrangements in quarter three at its September meetings as they pertain to the Shadow ICP, Shadow ICB and the arrangements for Local Care Partnerships upon which they will depend, noting that timescales for provider collaborative arrangements would need to be determined with those groups in parallel.

7.4. It is acknowledged that the Shadow ICB and arrangements for its population are dependent upon national and local appointment processes that create an interdependency upon its establishment even in Shadow form. As such there is an expectation that the current ICS Executive will continue to provide its current system leadership role until the point of hand over to the Shadow ICB and the Executive arrangements that will support it. This is less true of the Shadow ICP which will be established at the earliest opportunity.

Appendix A - The ICS NHS Body will:

- Developing a plan to meet the health needs of the population (all ages) within their area, having regard to the Partnership's strategy.
- Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital).
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.
- Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including:
    - Putting contracts and agreements in place to secure delivery of its plan by providers.
    - Convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes
    - Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.
- Leading system implementation of the People Plan by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.
- Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
- Working in collaboration with councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability.
- Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England.
- Functions NHS England will be delegating including commissioning of primary care and appropriate specialised services.

Appendix B - ICP Principles (Integrated Care System: Design Framework)

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. Systems are invited to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online
5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.